D H E C
PROMOTE PROTECT PROSPER
VaxCare

Parental Consent for Seasonal Influenza Vaccination

SCHOOL: _____

CLINIC ID: _____

IF YOU DO NOT WANT YOUR CHILD TO RECEIVE THE INFLUENZA (FLU) VACCINE AT SCHOOL, DO NOT COMPLETE THIS FORM. If you want your child to receive the flu vaccine at school, complete this form and return it to your child's school. Please read the Vaccine Information Statements for the 2011-2012 Seasonal Influenza Vaccine (Inactivated and Live, Intranasal) provided with this form. If you have any questions, please call DHEC at the number included in the letter that came with this form.

Section 1: Student Information (PLEASE PRINT.)

Child's Last Name:		Child's First Name:	
Grade:	Age:	DOB:_____/_____/_____	Gender: ❑ Male ❑ Female
Address:		City:	Zip Code:
Home Phone: ( )		Emergency Contact Number: ( )	
Parent/Guardian Name:			
Race: ❑ White ❑ Black ❑ Asian ❑ American Indian ❑ Alaska Native ❑ Other:_____		Ethnicity: ❑ Hispanic ❑ Non-Hispanic	

Section 2: Medical Screening (PLEASE ANSWER ALL QUESTIONS.)

1. Has your child ever had a serious reaction to eggs OR a serious reaction to a previous flu vaccine (seasonal or H1N1) that caused any of the following: wheezing, trouble breathing, hives and itching all over the body, swelling in the mouth or throat, very low blood pressure or shock?	❑ Yes ❑ No
2. Has your child ever had Guillain-Barre Syndrome (a rare type of temporary severe muscle weakness and paralysis)?	❑ Yes ❑ No
3. Has your child ever had a serious (life threatening) allergy to latex?	❑ Yes ❑ No

If you answered YES to any of the questions above, your child cannot receive the 2011-2012 seasonal influenza vaccine at school. Please contact your primary healthcare provider about the flu vaccine. If you answered **NO** to all of the questions above, please answer questions #4 – #11 below:

4. Did your child receive at least one dose of influenza vaccine last year?	❑ Yes ❑ No ❑ Unsure
5. Has your child received any vaccine(s) within the past 30 days? If yes, list: Vaccine(s) Name: Date given:	❑ Yes ❑ No
6. Does your child have any of the following: asthma, diabetes (or other type of metabolic disease), or disease of the lungs, heart, kidneys, liver, nerves or blood (including anemia)?	❑ Yes ❑ No
7. Does your child take aspirin or a medication that contains aspirin every day?	❑ Yes ❑ No
8. Does your child have a weak immune system? (For example, treatment for cancer or HIV/AIDS or taking medications such as steroids may cause the immune system to be weak.)	❑ Yes ❑ No
9. Is your child pregnant or nursing? (Please discuss this question with your child for verification.)	❑ Yes ❑ No
10. Does your child have close contact with a person who needs care in a protected environment? (For example, someone who is in a bone marrow transplant unit.)	❑ Yes ❑ No
11. If your child is 2-4 years old, has your child had wheezing in the past 12 months?	❑ Yes ❑ No

If your child receives an antiviral medication (Tamiflu, Relenza, Amantadine, or Rimantadine) within 48 hours before or after the scheduled school vaccination clinic, please contact the school nurse.

NOTE: PLEASE TURN THE FORM OVER AND COMPLETE SECTION 3.

THE FOLLOWING SECTION WILL BE COMPLETED WHEN THE VACCINE IS GIVEN. (For Official use only)

Seasonal Influenza Vaccine (Inactivated)	❑ VFC ❑ VaxCare	Dose # ❑ 1 ❑ 2	Route: IM	❑ LA ❑ LL ❑ RA ❑ RL	Manufacturer:	Lot #:	VIS Date: 7/26/11
Seasonal Influenza Vaccine (Live, Intranasal)	❑ VFC ❑ VaxCare	Dose # ❑ 1 ❑ 2	Route: Intranasal L	L and R Nare	Manufacturer:	Lot #:	VIS Date: 7/26/11

❑ "What to Know After Your Child's Seasonal Flu Vaccine" given to student.

❑ Unable to vaccinate student due to: _____; "Unable to Vaccinate "form given to student.

Nurse Signature: Provider ID: Date:

Turn Page Over

Section 3: Authorization and Consent for Child's Vaccination
(PLEASE COMPLETE THE APPROPRIATE QUESTIONS BELOW AND SIGN AT THE BOTTOM TO INDICATE YOUR AGREEMENT AND CONSENT TO THE VACCINATION.)

Please check the appropriate box and supply the requested information under the checked box.

❑ **Private Insurance**

Insured First Name: _____ Insured Last Name: _____

Student's Relationship to the Insured: ❑ Dependent ❑ Self

Primary Insurance Company _____

Member/Insured ID_____ Group ID _____

Secondary Insurance Company _____

Member/Insured ID_____ Group ID _____

By signing below, I consent to the use and disclosure of my child's personal health information for the purpose of health care operations, along with the assignment of all payments from the insurer listed above to VaxCare for the services rendered. I understand I will be responsible for payment for the influenza vaccine if my insurance company does not pay. I acknowledge that I have been provided with a copy of VaxCare's Privacy Notice.

❑ **Medicaid**

Child's Medicaid Number (Recipient Number): _____

By signing below, I request that payment of Medicaid benefits be made on my behalf to the South Carolina Department of Health and Environmental Control (DHEC) for any services provided to my child. I give DHEC permission to exchange my child's medical or other confidential information as necessary to the Centers for Medicare and Medicaid Services (CMS), its agents, or other agents needed to determine benefits related to services provided. I agree to participate in treatment plans and to assignment of Medicaid benefits to DHEC for services rendered. I acknowledge that I have been given a copy of DHEC's Privacy Notice.

❑ **No Insurance**

I have no insurance or Medicaid coverage for my child.

❑ **American Indian/Alaskan Native**

VACCINE AUTHORIZATION (Please read carefully)

I CONSENT for my child to receive the seasonal flu vaccine at school. I have read or had explained to me the 2011-2012 Influenza Vaccine Information Statements. I have had an opportunity to ask questions about the vaccines. I understand the risks and benefits. I understand that the vaccine may be given as a shot or as a nasal spray. I have read and answered the questions in Section 2 carefully and accurately, and I understand that incorrect information could cause serious risks to my child. I consent to my child receiving a second dose of the seasonal flu vaccine at a school clinic if my child is less than 9 years old and a second dose is recommended by the U.S. Centers for Disease Control and Prevention (CDC). I agree to notify the school before the school vaccination clinic day if there is a change in my child's health or if I decide to get a 1st or 2nd dose of the seasonal flu vaccine for my child elsewhere. In case of occupational exposure, I consent to my child's blood testing if necessary for child and employee safety. I understand that immunization information about my child will be reported to the SC Immunization Registry for public health purposes.

Signature of Parent/Legal Guardian: _____ **Date:** _____

Print your name: _____

Instructions for Completing the Parental Consent for Seasonal Influenza Vaccination (DHEC 3123)

PURPOSE: To provide parents with a method to consent to their child receiving the seasonal influenza (flu) vaccine and to provide a documentation tool for vaccination in a **school setting**.

School and Clinic ID - When DHEC enters the school flu clinic date(s) in the VaxCare system via a restricted portal, that system generates a clinic ID number. Appropriate DHEC staff will enter that number and school name in the top, right corner of page 1.

Section 1- Student Information (completed by the child's parent/guardian)
Child's Last Name and First Name
Child's Grade
Child's Age
Child's Date of Birth
Child's Gender
Address, City, and Zip
Home Phone Number
Emergency Contact Phone Number
Parent/Guardian Name
Race (if "Other", enter race)
Ethnicity

Section 2- Medical Screening Questions for Seasonal Influenza Vaccine (TIV and LAIV) (completed by the child's parent/ guardian)
If the answer to any of questions 1-3 is "yes", the child cannot receive the 2011-2012 seasonal influenza vaccine at school. The parent or guardian needs to contact the child's primary healthcare provider about the flu vaccine.
If the answer to all questions 1-3 is "no", the parent or guardian will answer questions 4-11.

The nurse administering the vaccine will review the responses to the medical screening questions, determine the vaccine to be given and document the appropriate information in the "official use only" section at the bottom of page 1.

- Review information completed by the parent/guardian on page 2 of the form. Students who have private insurance are VaxCare patients. The Nurse will check "VaxCare" in the vaccination documentation section for those students. All other students (Medicaid, uninsured, or American Indian/Alaskan Native) are VFC eligible and are DHEC patients. The nurse will check "VFC" in the vaccination documentation section for those students.
- Dose #: Check dose being given.
- Site: Check appropriate box. (LA--Left Arm; RA--Right Arm; :LL--Left Leg; RL--Right Leg)
- Manufacturer: Document manufacturer name.
- Lot #: Document lot number.
- If the child received the influenza vaccine, check the box beside "What To Know After Your Child's Seasonal Flu Vaccine" to indicate that document was sent home with the student.
- If the nurse was unable to vaccinate the child, check the box beside "Unable to Vaccinate Student" to indicate the "Unable to Vaccinate" form was sent home with the student.

Nurse Signature: The nurse administering vaccine(s) enters his/her full legal signature.
Provider ID: The nurse enters his/her region assigned billing code.
Date: Document month/day/year vaccine administered.

Section 3 - Authorization and Consent for Child's Vaccination (completed by the child's parent/guardian)
The parent/guardian will complete the appropriate questions, sign and print their name and date the form at the bottom of the page to indicate their agreement and consent to the child's vaccination at the school located clinic.

OFFICE MECHANICS and FILING
VFC Eligible Students - Enter information into CARES and batch file the forms according to agency health records policies.
VAXCARE Eligible Students - Submit the forms to VaxCare per their guidelines. These are NOT DHEC patients. DO NOT enter any information, including immunization data, into CARES. VaxCare will make medical records for these patients.
Any Students We Were Unable to Vaccinate - DO NOT enter any data into CARES. File the forms with the VFC Eligible forms.